PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2003- 2005
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board

License No._____

File No._____

(For Board Use Only)

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

_____ACTIVE STATUS $400.00
_____INACTIVE STATUS $200.00……***(INACTIVE STATUS DOES NOT PERMIT THE PRACTICE OF MEDICINE INCLUDING THE WRITING OF PRESCRIPTIONS IN NEVADA)***
_____I REQUEST NON-RENEWAL OF MY LICENSE*
(*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW)

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

Request for NON-RENEWAL of License to Practice Medicine In Nevada

I hereby represent that I am the person named in this *APPLICATION FOR REGISTRATION RENEWAL* of license to practice medicine in the state of Nevada.

By signing on the signature line below, I am requesting that my license to practice medicine in Nevada NOT be renewed by the Nevada State Board of Medical Examiners. I will return this signed form to the board office.

_____ _____
Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**

PLEASE NOTE:

- **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2005. COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2005 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.)**
- **YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM IS PUBLIC INFORMATION.**

PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration renewal requires the submission of proof of completion of 40 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics and 20 hours of CME in your scope of practice or specialty **completed during the period July 1, 2003 through June 30, 2005**. Additionally, pursuant to Nevada Revised Statutes (NRS) 630.253(2)(b), an applicant must complete a course of instruction relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. "The course must provide at least 4 hours of instruction that includes instruction in the following subjects: (1) An overview of acts of terrorism and weapons of mass destruction; (2) Personal protective equipment required for acts of terrorism; (3) Common symptoms and methods of treatment associated with exposure to, or injuries caused by, chemical, biological, radioactive and nuclear agents; (4) Syndromic surveillance and reporting procedures for acts of terrorism that involves biological agents; and (5) An overview of the information available on, and the use of, the Health Alert Network." Submit your proof of completion of CME with your completed *Application for Registration Renewal* form. (See last page of this form for CME statement.)

2. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

3. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name____

Street____

City______________________County____________________State_____________________Zip_________________

Phone Number_____________________________

4. Indicate below your primary and secondary scopes of practice using the following codes:

SCOPES OF PRACTICE CODES

1 ADDICTION MEDICINE
2 ADOLESCENT MEDICINE
3 AEROSPACE MEDICINE
4 ALLERGY
5 ALLERGY/IMMUNOLOGY
6 AMBULATORY MEDICINE
7 ANESTHESIOLOGY
8 BLOODBANKING
9 BRONCO-ESOPHAGOLOGY
10 CARDIOVASCULAR DISEASES
11 CATSCAN/ULTRASOUND
12 CHILD NEUROLOGY
13 CHILD PSYCHIATRY
14 CLINICAL PHARMACOLOGY
15 CRITICAL CARE
16 DERMATOLOGY
17 DERMATOPATHOLOGY
18 EMERGENCY MEDICINE
19 ENDOCRINOLOGY
20 FAMILY PRACTICE
21 FORENSIC MEDICINE
22 GASTROENTEROLOGY
23 GENERAL PRACTICE
24 GERIATRIC PSYCHIATRY
25 GERIATRICS
26 GYNECOLOGY
27 HAIR TRANSPLANTATION
28 HEMATOLOGY
29 HOMEOPATHY
30 HYPNOSIS
31 IMMUNOLOGY
32 INFECTIOUS DISEASES
33 INFERTILITY
34 INTERNAL MEDICINE
35 LARYNGOLOGY
36 LEGAL MEDICINE
37 MATERNAL/FETAL MEDICINE
38 MEDICAL ACUPUNCTURE
39 MEDICAL ETHICS
40 MEDICAL GENETICS
41 NEO/PERINATAL MEDICINE
42 NEOPLASTIC DISEASES
43 NEPHROLOGY
44 NEUROLOGY
45 NEURO-OPHTHALMOLOGY
46 NEUROPATHOLOGY
47 NEURORADIOLOGY
48 NEUROTOLOGY
49 NON-CONVENTIONAL MEDICINE
50 NUCLEAR MEDICINE
51 NUTRITION
52 OBSTETRICS
53 OBSTETRICS/GYNECOLOGY
54 OCCUPATIONAL MEDICINE
55 ONCOLOGY
56 ONCOLOGY, GYNECOLOGICAL
57 ONCOLOGY, HEMATOLOGY
58 ONCOLOGY, RADIATION
59 ONCOLOGY, SURGICAL
60 OPHTHALMOLOGY
61 OTOLARYNGOLOGY
62 OTOLOGY
63 PAIN MANAGEMENT
64 PATHOLOGY
65 PATHOLOGY, ANATOMIC
66 PATHOLOGY, CLINICAL
67 PATHOLOGY, FORENSIC
68 PEDIATRIC, ALLERGY
69 PEDIATRIC, ANESTHESIOLOGY
70 PEDIATRIC, CARDIOLOGY
71 PEDIATRIC, CRITICAL CARE
72 PEDIATRIC, EMERGENCY MEDICINE
73 PEDIATRIC, ENDOCRINOLOGY
74 PEDIATRIC, GASTROENTEROLOGY
75 PEDIATRIC, HEMATOLOGY/ONCOLOGY
76 PEDIATRIC, INFECTIOUS DISEASES
77 PEDIATRIC, INTENSIVIST
78 PEDIATRIC, NEPHROLOGY
79 PEDIATRIC, NEUROLOGY
80 PEDIATRIC, OPHTHALMOLOGY
81 PEDIATRIC, PHYSIATRY
82 PEDIATRIC, PULMONARY
83 PEDIATRIC, RADIOLOGY
84 PEDIATRIC, RHEUMATOLOGY
85 PEDIATRIC, SURGERY
86 PEDIATRIC, UROLOGY
87 PEDIATRICS
88 PHYSICAL MEDICINE/REHABILITATION
89 PREVENTIVE MEDICINE
90 PSYCHIATRY
91 PSYCHOANALYSIS
92 PSYCHOMATIC MEDICINE
93 PUBLIC HEALTH
94 PULMONARY DISEASES
95 OCCUPATIONAL MEDICINE
96 RADIOLOGY
97 RADIOLOGY, DIAGNOSTIC
98 RADIOLOGY, INTERVENTIONAL
99 RADIOLOGY, NUCLEAR
100 RADIOLOGY, THERAPEUTIC
101 RADIOLOGY, VASCULAR
102 RHEUMATOLOGY
103 RHINOLOGY
104 SLEEP DISORDERS
105 SPORTS MEDICINE
106 SURGERY, ABDOMINAL
107 SURGERY, CARDIOTHORACIC
108 SURGERY, CARDIOVASCULAR
109 SURGERY, COLON/RECTAL
110 SURGERY, CRANIOFACIAL
111 SURGERY, GENERAL
112 SURGERY, HAND
113 SURGERY, HEAD/NECK
114 SURGERY, MAXILLOFACIAL
115 SURGERY, NEUROLOGICAL
116 SURGERY, ORTHOPEDIC
117 SURGERY, PLASTIC
118 SURGERY, THORACIC
119 SURGERT, TRANSPLANT
120 SURGERY, TRAUMATIC
121 SURGERY, UROLOGIC
122 SURGERY, VASCULAR
123 TOXICOLOGY
124 TRANSPLANTATION
125 URGENT CARE
126 UROLOGY

Primary Scope of Practice **Code** ___________

Secondary Scope of Practice **Code** ___________

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All of the following questions refer to the time period July 1, 2003, through the present date only.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without

the use of aids or devices, such as voice amplifiers; and

3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? _____Yes _____No

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____Yes _____No _____N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? _____Yes_____No _____N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? _____Yes _____No_____N/A

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? _____Yes _____No

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not** considered **a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? _____Yes _____No

7. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? _____Yes _____No

8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _____Yes _____No

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? _____Yes_____No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? _____Yes _____No

11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency <u>other than</u> the Nevada State Board of Medical Examiners? _____Yes _____No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _____Yes_____No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)

(If more space is needed, attach a separate sheet.)

CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

Please place a check mark next to one of the following statements:

_____ (a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism, during the past biennial period of July 1, 2003 through June 30, 2005;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2004 through June 30, 2004, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2004 through December 31, 2004, the third six months of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism;

_____ (d) I was initially licensed in Nevada during the time period January 1, 2005 through June 30, 2005, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty, and an additional 4 hours of AMA Category 1 continuing medical education in acts of terrorism; **OR**

_____ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2003 through June 30, 2005.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **IF YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JULY 1, 2003 THROUGH JUNE 30, 2005 ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING.**
- **YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

I HAVE____ HAVE NOT ____ ***(CHECK ONE)*** ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.

BY SIGNING ON THE SIGNATURE LINE BELOW:

1) **I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR REGISTRATION RENEWAL* OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;**
2) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND**
3) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME), OR RESIDENCY OR FELLOWSHIP TRAINING COMPLETION; (b) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (c) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).**

_____ _____

Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**